SOUTH DAKOTA
DEPARTMENT
OF HEALTH

PUBLIC HEALTH BULLETIN

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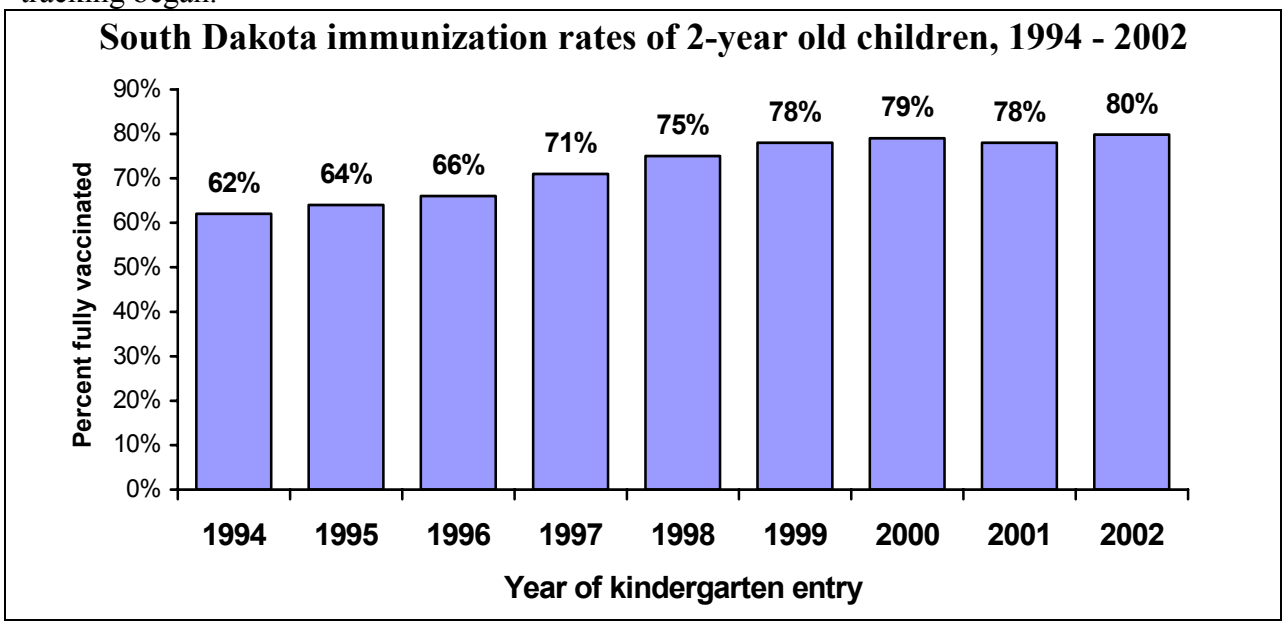
In this issue:

2002 South Dakota Retrospective Immunization Survey

The South Dakota immunization survey shows that 80% of the state's children entering kindergarten in fall 2002 were adequately immunized when they were 24 months old. Across the state 10,282 vaccination records from 418 schools were reviewed, with 8205 of the children determined to have been fully immunized (80%). This is this highest vaccination rate since the tracking began.



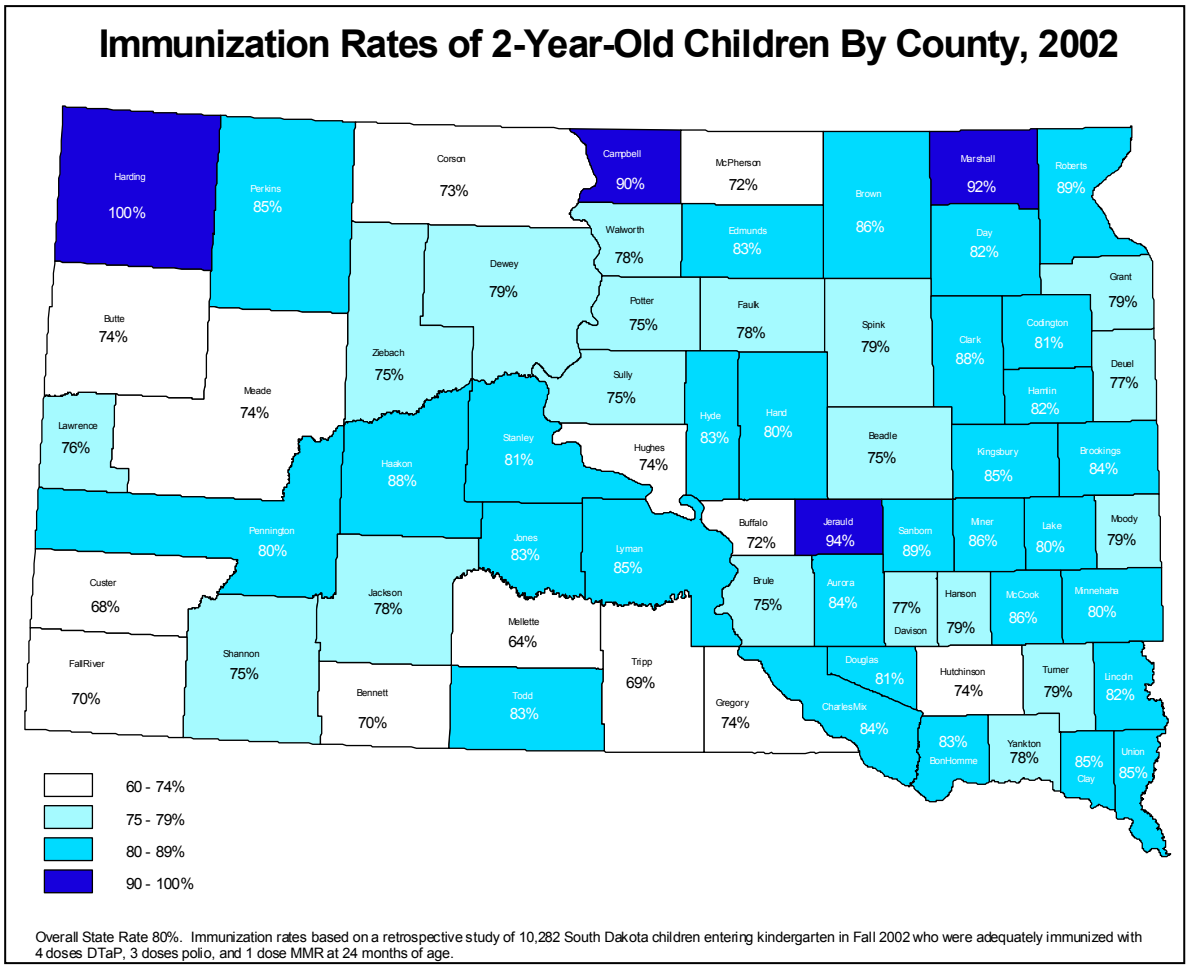
The statewide goal is 90% of 2-year old children with full immunization coverage. Harding County had the highest immunization rate in 2002 with 100% of their children fully immunized. Three other counties achieved the goal, Jerauld 94%, Marshall 92%, and Campbell 90%. Jerauld County has met the 90% goal for the past 3 years. Three counties had less than 70% coverage, Tripp 69%, Custer 68%, and Mellette 64%. Between 2000 and 2002, the rates in 42 counties

increased, 64%; while the rates in 22 counties decreased, 33%. Two counties did not change their rates.

Many children were very close to being fully immunized. In 2002, 8967 children, 87%, had all their immunizations, except their forth DTaP. Parents and health-care providers are urged to get children the forth DTaP between 15 and 18 months.

Every year the immunization records of all children entering kindergarten are reviewed by their local school to make sure they have all the immunizations required by state law. The immunization rates reported are the percentages of this year's kindergarten students who were adequately immunized with 4 doses of DTaP (diphtheria, tetanus, pertussis), 3 doses of polio, and 1 dose of MMR (measles, mumps, rubella) when they were 24 months of age. We are measuring immunization rates of the kindergarteners as they turned 2-years old. This is called a retrospective survey.

This retrospective survey identifies communities with low immunization rates that may need targeted help to improve. A high immunization rate protects the whole community by limiting the number of individuals who are susceptible to infectious diseases and limits the spread of diseases. Thanks to immunization, South Dakota was free of diphtheria, measles, mumps, rubella, tetanus, or polio in 2002. We had, however, 7 cases of pertussis (whooping cough). Immunization schedules are available online at www.cdc.gov/nip or by calling the South Dakota Department of Health Immunization Coordinator (1-800-592-1861). The Department of Health also has vaccine record cards available.



Overall State Rate 80%. Immunization rates based on a retrospective study of 10,282 South Dakota children entering kindergarten in Fall 2002 who were adequately immunized with 4 doses DTaP, 3 doses polio, and 1 dose MMR at 24 months of age.

Immunization rates of 2-year old children by County, 2002, 2001 and 2000

Based on a retrospective study of South Dakota children entering kindergarten who were fully immunized with 4 doses of DTaP, 3 doses of polio, and 1 dose of MMR when they were 24 months old.

County	Records reviewed	Fully immunized	2002	2001	2000	Change 2000- 2002
Aurora	38	32	**84%**	74%	78%	+6%
Beadle	182	136	**75%**	80%	80%	-5%
Bennett	77	54	**70%**	48%	54%	+16%
Bon Homme	88	73	**83%**	77%	81%	+2%
Brookings	310	260	**84%**	84%	83%	+1%
Brown	429	367	**86%**	81%	84%	+2%
Brule	68	51	**75%**	83%	67%	+8%
Buffalo	32	23	**72%**	85%	53%	+19%
Butte	120	89	**74%**	73%	69%	+5%
Campbell	20	18	**90%**	85%	68%	+22%
Charles Mix	152	128	**84%**	83%	84%	0%
Clark	49	43	**88%**	85%	84%	+3%
Clay	122	104	**85%**	80%	86%	-1%
Codington	299	243	**81%**	82%	83%	-2%
Corson	60	44	**73%**	78%	81%	-7%
Custer	68	46	**68%**	57%	70%	-3%
Davison	281	216	**77%**	78%	75%	+2%
Day	71	58	**82%**	79%	84%	-2%
Deuel	35	27	**77%**	87%	89%	-12%
Dewey	161	127	**79%**	63%	62%	+17%
Douglas	53	43	**81%**	84%	78%	+3%
Edmunds	41	34	**83%**	72%	85%	-2%
Fall River	79	55	**70%**	77%	74%	-4%
Faulk	36	28	**78%**	94%	88%	-10%
Grant	102	81	**79%**	83%	77%	+2%
Gregory	54	40	**74%**	75%	71%	+3%
Haakon	25	22	**88%**	89%	80%	+8%
Hamlin	91	75	**82%**	91%	76%	+6%
Hand	40	32	**80%**	88%	91%	-11%
Hanson	47	37	**79%**	84%	70%	+9%
Harding	8	8	**100%**	56%	68%	+32%
Hughes	208	154	**74%**	77%	76%	-2%
Hutchinson	124	92	**74%**	82%	87%	-13%
Hyde	23	19	**83%**	62%	50%	+33%
Jackson	45	35	**78%**	83%	60%	+18%
Jerauld	17	16	**94%**	90%	93%	+2%
Jones	6	5	**83%**	71%	75%	+8%
Kingsbury	61	52	**85%**	76%	74%	+11%
Lake	138	111	**80%**	81%	78%	+2%
Lawrence	152	116	**76%**	70%	68%	+8%
Lincoln	249	204	**82%**	79%	81%	+1%
Lyman	60	51	**85%**	77%	83%	+2%
Marshall	52	48	**92%**	87%	87%	+5%
McCook	76	65	**86%**	78%	82%	+4%
McPherson	36	26	**72%**	91%	94%	-21%
Meade	210	155	**74%**	67%	79%	-6%
Mellette	22	14	**64%**	81%	84%	-20%
Miner	28	24	**86%**	89%	74%	+11%
Minnehaha	2384	1904	**80%**	79%	80%	0%
Moody	72	57	**79%**	79%	80%	-1%
Pennington	1403	1121	**80%**	78%	78%	+1%
Perkins	33	28	**85%**	79%	83%	+2%
Potter	36	27	**75%**	71%	89%	-14%
Roberts	159	142	**89%**	85%	90%	-1%
Sanborn	36	32	**89%**	81%	87%	2%
Shannon	340	255	**75%**	69%	68%	+7%
Spink	84	66	**79%**	87%	83%	-4%
Stanley	37	30	**81%**	68%	71%	+10%
Sully	12	9	**75%**	85%	73%	+2%
Todd	224	186	**83%**	76%	79%	+4%
Tripp	67	46	**69%**	63%	65%	+3%
Turner	97	77	**79%**	67%	68%	+11%
Union	198	168	**85%**	77%	81%	+4%
Walworth	65	51	**78%**	78%	74%	+5%
Yankton	266	207	**78%**	77%	80%	-2%
Ziebach	24	18	**75%**	82%	78%	-3%
TOTAL	**10282**	**8205**	**80%**	78%	79%	+1%

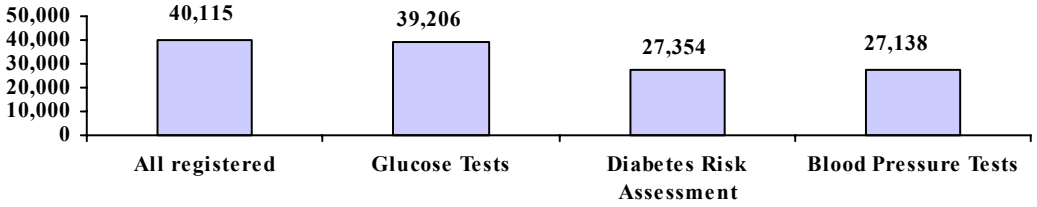
2002 South Dakota diabetes screening project

Diabetes is a growing public health problem and is now the sixth leading cause of death in the U.S. Among U.S. adults, diagnosed diabetes increased 49% from 1990 to 2000. Similar increases are expected in the next decade and beyond. In order to raise public awareness about diabetes and to identify persons with hypertension, abnormal random blood glucose levels and to measure risk for diabetes, the South Dakota Department of Health conducted a statewide, diabetes screening program during the period from July to December 2002. The goal was to reach an even greater number of South Dakotans than the 30,981 screened in a similar initiative in 2001. Participants were offered blood glucose testing, diabetes risk assessments and blood pressure checks. Those with results that indicated further evaluations were counseled to visit their primary care physicians.

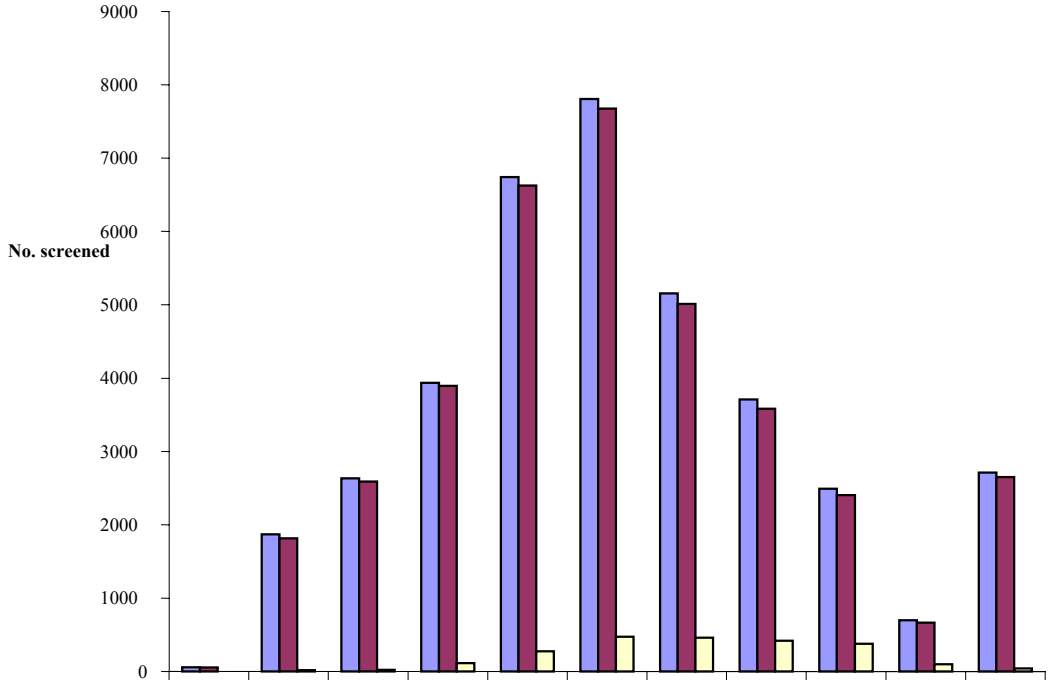
- 40,115 persons were registered; 58 percent were male and 37 percent female. Gender was not noted for all participants. Ages ranged from less than one year to over 85 years.
- 39,206 blood glucose tests were done; 3,963, or 10 percent, were ≥ 140 mg/dL.
- 36,967 of blood glucose tests were on persons who were either not previously diagnosed or did not know if they had diabetes; 2,984, or 8 percent, of these were high, i.e., ≥ 140 mg/dL
- 27,354 risk assessments for diabetes were done with 15,196, or 55.5 percent, found to be high risk, i.e., ≥ 10 (a copy of the risk assessment is available in the summary report at www.sddiabetes.net)
- 27,138 blood pressures were done with 2,320, 8.5 percent, found to be high, i.e., systolic ≥ 140 and diastolic ≥ 90.
- 5,284 persons were referred to their primary physicians either because of high blood pressure or high glucose levels, regardless of diagnosis history.
- Among individuals who were fasting and either had not been previously diagnosed with diabetes or did not know whether they had been diagnosed, 507 were found with blood glucose levels 110 mg/dL or higher. Those with fasting glucose levels between 110 and 126 mg/dL were counseled about pre-diabetes. The rest were advised to seek further evaluation by their physicians.
- 2,696 children ≤ 18 years of age were screened; 100 had blood glucose levels ≥ 140 mg/dL.
- 19,797 or 47 percent of all individuals registered had all three services offered, i.e. glucose testing, blood pressures and diabetes risk assessment.

Abbreviations used in the following graphs and tables include: BG = blood glucose; BP = blood pressure; Dx = diagnosis; RA = risk assessment; and Unk = unknown.

All registered, All Glucose Tests, All Diabetes Risk Assessments and All Blood Pressures, South Dakota Diabetes Screening Program 2002



Glucose Tests by Age Groups and Diagnosis History, South Dakota 2002



	0 - 4	5 - 14	15 -24	25-34	35-44	45-54	55-64	65-74	75-84	85+	UNK.
Glucose tests	57	1872	2633	3937	6740	7807	5157	3710	2493	697	2712
No prev dx or unk	55	1813	2589	3895	6625	7676	5014	3582	2404	664	2650
Prev. dx	1	18	20	112	275	474	459	422	380	97	42

Age Groups

Number of Screenings Registered and Glucose Tests by Race and Diagnosis History, South Dakota 2002

	Whites	Native American	Hispanics	Blacks	Asians	Unknown	TOTAL
No. registered	36,012	2,546	213	70	113	1,161	40,115
No. of glucose tests	35,155	2,518	210	69	110	1,141	39,203
No. of increased glucose*	3,475	366	14	4	9	95	3,963
Previous diabetes diagnosis	871	88	3	1	6	10	979
No previous diagnosis or unknown	2,604	278	11	3	3	85	2,984

*Blood Glucose ≥ 140 mg/dL

Number of Individuals Screened by County (n=40,115), South Dakota 2002

Aurora	209	Corson	40	Hand	255	Marshall	513	Spink	997
Beadle	1,790	Custer	437	Hanson	338	McCook	96	Stanley	483
Bennett	207	Davison	1,981	Harding	27	McPherson	215	Sully	46
Bon Homme	371	Day	545	Hughes	2,235	Meade	2,108	Todd	31
Brookings	1,644	Deuel	227	Hutchinson	204	Mellette	0	Tripp	442
Brown	2,992	Dewey	153	Hyde	64	Miner	822	Turner	434
Brule	166	Douglas	75	Jackson	206	Minnehaha	3,277	Union	591
Buffalo	0	Edmunds	412	Jerauld	474	Moody	439	Walworth	255
Butte	160	Fall River	268	Jones	25	Pennington	3,409	Yankton	1,786
Campbell	0	Faulk	151	Kingsbury	49	Perkins	77	Ziebach	100
Charles Mix	311	Grant	434	Lake	942	Potter	122		
Clark	339	Gregory	220	Lawrence	666	Roberts	371		
Clay	401	Haakon	292	Lincoln	26	Sanborn	406		
Codington	1,718	Hamlin	384	Lyman	215	Shannon	1,442		

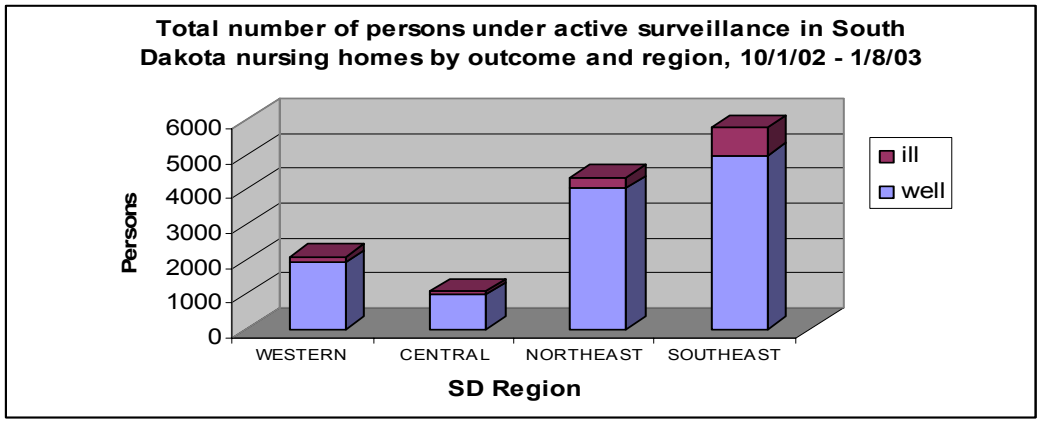
To view the summary reports for both the 2001 and 2002 screening projects, visit the web at www.sddiabetes.net.

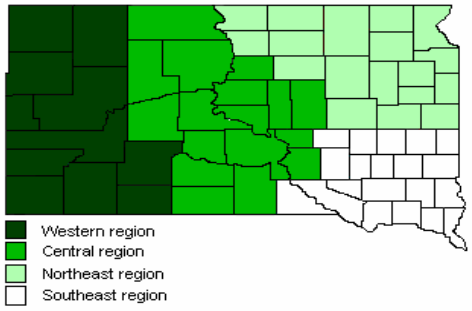
Norovirus outbreaks in South Dakota nursing homes, winter 2002-2003

Norovirus is the recently approved term for the agent that has previously been called Norwalk or Norwalk-like virus. Known to the general public as cruise ship virus, it is also responsible for what has been called "winter vomiting disease" and stomach flu. To epidemiologists, however, noroviruses are known to cause acute gastroenteritis in humans, with outbreaks commonly associated with food establishments as well as institutional and semi-enclosed settings such as nursing homes. Because humans are the only known reservoir for noroviruses, lapse in personal or environmental hygiene is a determinant of many outbreaks. While norovirus infection is not known to cause severe or prolonged symptoms of disease, outbreaks in institutional settings can quickly exhaust resources and leave significant financial burdens behind.

Armed with new testing capabilities for norovirus at the Department of Health Public Health Laboratory, active surveillance was conducted to quantify the impact in South Dakota nursing homes for the first time. Active surveillance revealed that an average of 14% of nursing home residents and 7% of staff statewide became ill with acute gastrointestinal illness between October 1, 2002 and January 8, 2003. In addition to sporadic cases, a total of 17 outbreaks of acute gastroenteritis were identified. Ninety-eight stool specimens associated with nursing home outbreaks between October 1, 2002 and March 24, 2003 were analyzed and sixty-four (65%) specimens tested positive for norovirus. Results of active surveillance are summarized as follows.

SD Region	Ill Residents	Total Residents	% Ill Residents	Ill Staff	Total Staff	% Ill Staff	Total Ill
WESTERN	98	872	11%	61	1201	5%	159
CENTRAL	40	480	8%	41	590	7%	81
NORTHEAST	175	1818	10%	121	2534	5%	296
SOUTHEAST	538	2923	18%	264	2866	9%	802
STATEWIDE	851	6093	14%	487	7191	7%	1338





Norovirus is shed in an infected person's feces or vomit. Introduction of the virus onto food, beverage or utensils by unwashed hands of an infected care provider is one possible route of introduction into the nursing home setting. Outbreaks may be sustained when ingestion of the virus occurs in combination with person to person contact, environmental contamination and airborne droplet exposure. A number of properties of noroviruses make them especially suited to cause outbreaks among institutional settings, as summarized below:

- high attack rates (68% in one experimental study[1]).
- virus may be shed up to 2 weeks after symptoms resolve.[2, 3]
- low infectious dose <100 virions.[2, 4]
- high persistence of the agent in the environment[2].
- potential for multiple modes of transmission (i.e. droplets, fomites, person-to-person, environmental contamination[5]).
- percentage of cases with vomiting ≥50%.[2,6]
- absence of long-lasting immunity.[3, 6]
- potential for outbreaks involving multiple strains.

Heightening infection control practices between late fall to spring when community transmission may be greatest is especially important. Maintaining excellence in personal hygiene, combined with strict efforts to properly address environmental contamination are the most effective measures to prevent norovirus transmission. Reporting outbreaks of illness to the Department of Health (1-605-773-3737) immediately upon suspicion is required (SDCL 34-22-12 and ARSD 44:20) and will function to: 1) improve surveillance for norovirus within South Dakota; 2) secure access to resources to identify the infectious agent; and 3) obtain guidance for proper control of transmission.

References

1. Graham DY, Jiang X, Tanaka T, Opekun AR, Madore HP, Estes MK. Norwalk virus infection of volunteers: new insights based on improved assays. J Infect Dis 1994; 170: 34-43.
2. CDC Website, Technical Fact Sheet: http://www.cdc.gov/ncidod/dvrd/revb/gastro/norovirus-factsheet.htm
3. Okhuysen PC, Jiang Xi, Liming Ye, Johnson PC, Estes MK. Viral Shedding and Fecal IgA Response after Norwalk Virus Infection. J Infect Dis 1995; 171: 566-9.
4. Doultree JC, Druce JD, Birch CJ, Bowden DS, Marshall JA. Inactivation of feline calicivirus, a Norwalk virus surrogate. J Hosp Infect 1999; 41: 51-57.
5. Fankhauser RL, Noel JS, Monroe SS, Ando T, Glass RI. Molecular epidemiology of "Norwalk-like viruses" in outbreaks of gastroenteritis in the United States. J Infect Dis 1998; 178: 1571-8; and CDC, unpublished data, 1997-2000.
6. Morbidity and Mortality Weekly Report. Norwalk-Like Virus. CDC, June 1, 2001; 50(9): 1-17.

Death Certificate Filing Process Changes

During the 2003 legislative session, legislation was passed and signed by the Governor to improve the way that death certificates are filed. Senate Bill 26 was the result of a cooperative effort by participants in the death certificate process as well as their organizations. These statute changes will impact all those individuals who sign death certificates. Following are some frequently asked questions about the changes.

What are the changes?

- The Death Certificate will be divided into two parts – the Fact of Death Record and the Medical Certificate.
- Funeral directors will be responsible for filing the Fact of Death Record with the Department of Health within 5 days, bypassing the Register of Deeds.
- The Certifier (physician, physician assistant, nurse practitioner or coroner) will be responsible for filing the Medical Certificate with the Department of Health within 5 days.
- The system allows for electronic signatures and filing of death certificates.

Will I be required to use the Electronic Death Registration System?

No. All participants will have the option of completing the certificate either using a paper process or an electronic process or a combination of the two.

In the current process, the funeral director is responsible for providing the certificate to me to sign and for filing the certificate. How will I know when a death certificate needs to be completed and filed?

If you choose file a medical certificate using the electronic system, you will receive a message from the funeral director indicating that a medical certificate is available for you to complete. You also have the ability to designate a preferred method of communication such as phone or fax. If you designate phone or fax, the funeral director will contact you via phone or fax as well as send you a message.

If you choose to file a medical certificate by paper, the funeral director will provide you with a medical certificate to complete and submit to the Department of Health.

When will the changes be implemented?

Senate Bill 26 has a delayed implementation date of January 1, 2004. All participants in the death registration process will begin to use the new process for deaths that occur on or after January 1, 2004. In conjunction with the change in process, there will be a new standard certificate, which will change the format of the death certificate.

How should we prepare for this change in process?

DOH recommends working with your facility and physician group to determine the best process for achieving the filing of the medical certificate within 5 days of the date of death.

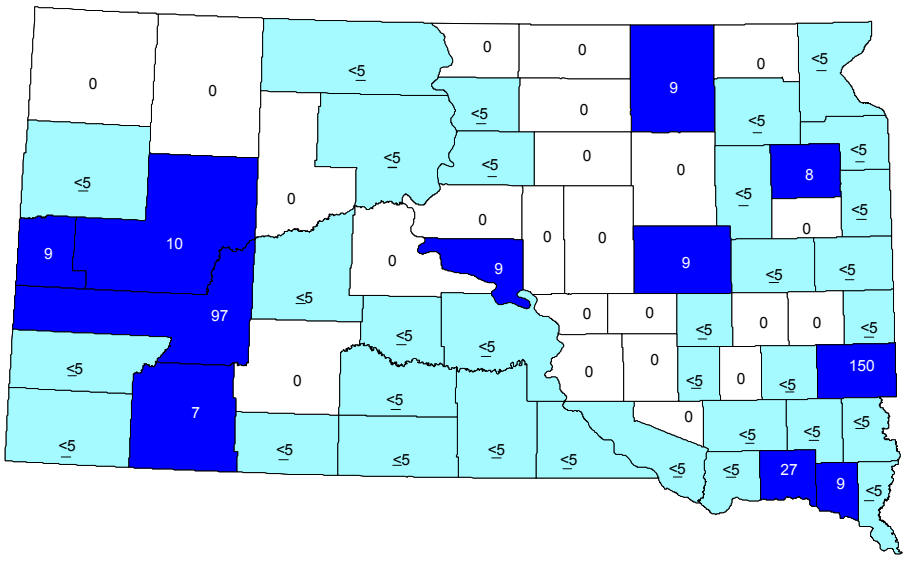
I am interested in filing the Medical Certificate using the Electronic Death Registration System. Where do I get more information?

If you would like to explore the option of using electronic filing, please contact Kathi Mueller, Manager of the Office of Data, Statistics and Vital Records at (605) 773-5303.

South Dakota Semi-Annual HIV/AIDS Surveillance Report
January 2003

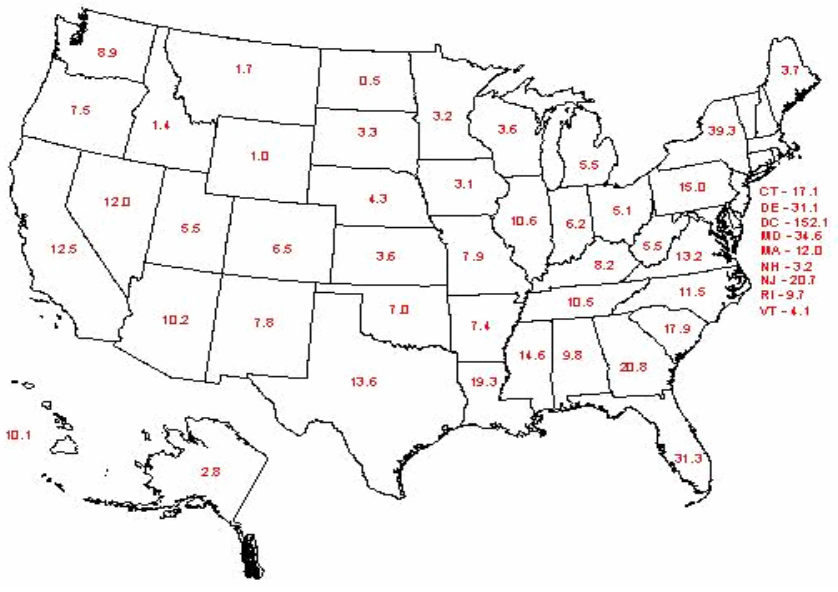
Four hundred and eighteen cumulative cases of HIV/AIDS were reported to the South Dakota Department of Health from 1985 through December 2002. During 2002 there were 21 new HIV/AIDS cases reported, 8 male and 13 female. During the previous year, 2001, 22 cases had been reported.

South Dakota Residents Reported Infected with HIV/AIDS: Cumulative Cases by County, 1985-2002



There are an estimated 289 people living with HIV/AIDS in South Dakota, 77% male and 23% female. Blacks and Native Americans are disproportionately affected by HIV/AIDS with 12% and 13% of the cases, compared to <1% and 9% of the population, respectively.

United States AIDS Incidence, 2001: Cases per 100,000



Source: Department of Health and Human Services HIV/AIDS Surveillance Report

South Dakota has among the lowest incidence of AIDS cases in the United States. In 2001 the South Dakota incidence rate was 3.3 cases per 100,000. The rate for the United States was 14.7 cases per 100,000.

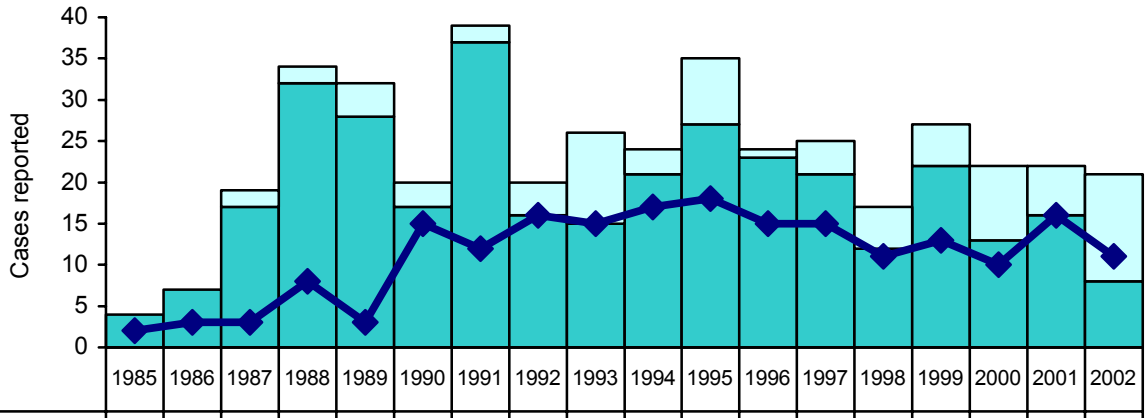
South Dakota HIV/AIDS Cumulative Statistics, 1985 - 2002

Residents reported infected with HIV since 1985	418
Residents currently living with HIV/AIDS	289
Male residents currently living with HIV/AIDS	222
Female residents currently living with HIV/AIDS	67
Residents reported who have been diagnosed with AIDS	203
Residents infected with HIV who have died (of all causes)	119
Residents who have been diagnosed with AIDS and have died	100
South Dakota AIDS Fatality Rate	49%
Out-of-state AIDS cases who have died in South Dakota	53

United States Cumulative AIDS Statistics through December 2001

AIDS Cases Reported in the United States	807,075
AIDS Deaths Reported in the United States	467,910
AIDS Fatality Rate in the United States	58%

South Dakota Residents by Gender Infected with HIV, 1985-2002



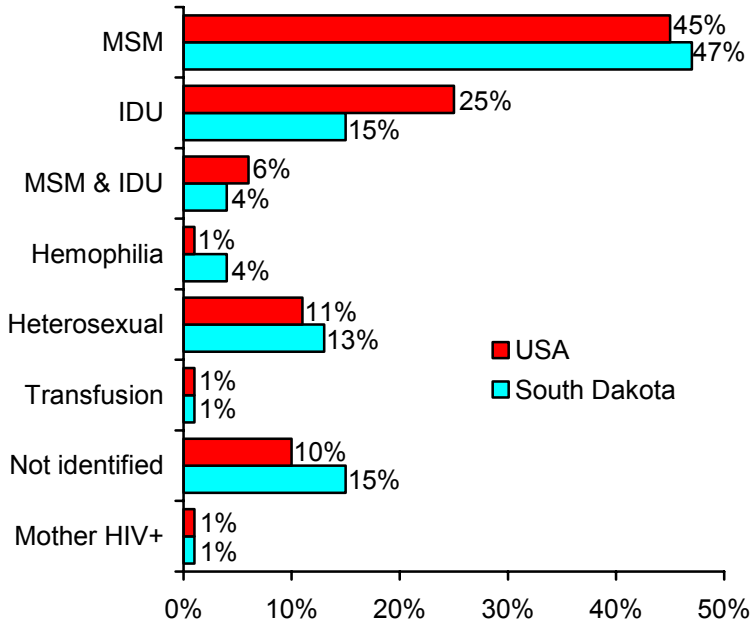
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
HIV (female)	0	0	2	2	4	3	2	4	11	3	8	1	4	5	5	9	6	13
HIV (male)	4	7	17	32	28	17	37	16	15	21	27	23	21	12	22	13	16	8
AIDS diagnosed	2	3	3	8	3	15	12	16	15	17	18	15	15	11	13	10	16	11

At the end of 2002, 418 SD residents had been reported as infected with HIV (336 male, 82 female) and 203 of those had also been diagnosed with AIDS. Some cases may have been reported as an HIV case in a different year than they were diagnosed with AIDS.

HIV/AIDS cases reported by race/ethnicity, sex, and age, SD, 1985-2002

Age at diagnosis	White		Native American		Black		Hispanic		All groups		Total
	Male	Female	Male	Female	Male	Female	Male	Female	M	F	
Under 5 yrs	2	1	1	2	0	0	1	0	**4**	**3**	**7**
5-12 yrs	3	0	1	0	0	0	0	0	**4**	**0**	**4**
13-19 yrs	10	1	0	1	1	0	1	1	**12**	**3**	**15**
20-29 yrs	76	20	14	6	8	5	4	1	**102**	**32**	**134**
30-39 yrs	112	13	16	9	14	6	2	0	**144**	**28**	**172**
40-49 yrs	38	8	4	2	3	1	1	0	**46**	**11**	**57**
50-59 yrs	11	4	3	0	1	1	1	0	**16**	**5**	**21**
≥60 yrs	8	0	0	0	0	0	0	0	**8**	**0**	**8**
Sub- Total	**260**	**47**	**39**	**20**	**27**	**13**	**10**	**2**	**336**	**82**	**418**
Total	**307**		**59**		**40**		**12**		**418**		

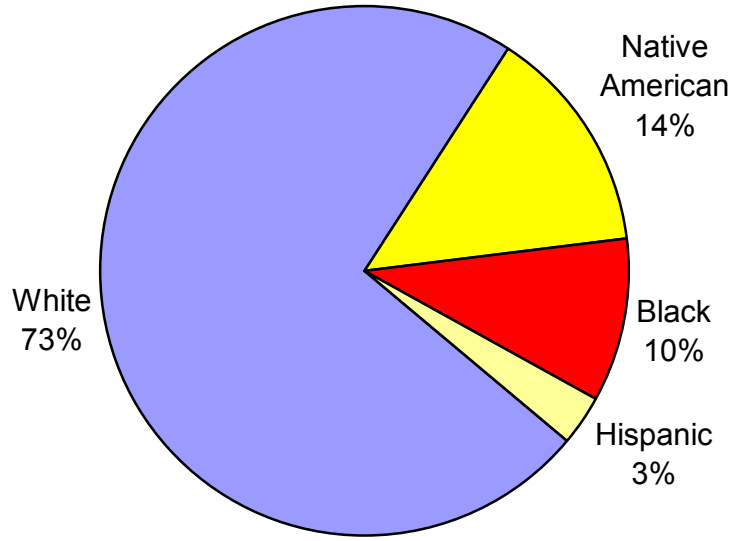
HIV AIDS Cases by Exposure Category*, SD** & USA***



*MSM (men who have sex with men)
*IDU (injection drug user)
**South Dakota HIV/AIDS cases 1985-2002
***US AIDS cases through 2001

Sometimes 2 or more exposures are reported for one case.
This table is consistent with the CDC hierarchy of exposures.

SD HIV/AIDS Cases by Race/Ethnicity, 1985-2002, (n = 418)



Since the beginning of the epidemic, males have accounted for the majority of the reported HIV/AIDS cases each year, except in 2002.

South Dakotans living with HIV/AIDS (n=289)

GENDER	Cases	Percent
Male	222	77%
Female	67	23%
Total	289	100%

RACE	Cases	Percent
White	206	71%
Native American	37	13%
Black	36	12%
Hispanic	10	3%
Total	289	100%

AGE	Cases	Percent
0-12 years	4	1%
13-19 years	4	1%
20-29 years	30	10%
30-39 years	108	37%
40-49 years	92	32%
50+ years	51	18%
Total	289	100%

RISK	Cases	Percent
MSM	136	47%
Injection drug use	49	17%
MSM and IDU	8	3%
Heterosexual	39	13%
Transfusion	2	1%
Hemophilia	4	1%
Mother HIV+	2	1%
No risk identified	49	16%
Total	289	100%

South Dakota Residents Reported with Associated Diseases, 1992-2002												
Diseases	Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
HIV/AIDS		20	26	24	35	24	25	17	27	22	22	21
Chlamydia trachomatis infections		1954	1643	1432	1317	1538	1439	1573	1554	1835	1821	2214
Gonorrhea		168	276	245	244	176	172	221	192	277	289	263
Herpes, genital and neonatal		84	88	110	102	102	94	142	275	339	345	310
Syphilis, Primary and Secondary		1	0	2	0	0	1	1	0	0	1	0
Chancroid		0	0	0	0	0	0	0	0	0	0	0
Hepatitis B		5	0	4	2	5	1	4	1	2	1	3

Department of Health Confidential HIV Testing Centers

For testing and counseling for HIV/AIDS and other sexually transmitted diseases, contact one of the following sites or call **1-800-592-1861.**

Aberdeen
402 S. Main St.
Aberdeen, SD 57401-4127
605-626-2373
1-866-805-1007 toll-free

Rapid City
909 E. St. Patrick, Suite 7
Rapid City, SD 57701
605-394-2289
1-866-474-8221 toll free

Watertown
913 5th St. SE
Watertown, SD 57201-5134
605-882-5096
1-866-817-4090 toll free

Sioux Falls
300 S. Phillips, Suite L104
Sioux Falls, SD 57104
605-367-5365
1-866-315-9214 toll free

Pierre
302 E Dakota
Pierre, SD 57501-3133
605-773-5348
1-866-229-4927 toll free

Dupree
Ziebach County Court House
Dupree, SD 57623-0068
605-365-5164

National AIDS Hotline
1-800-342-2437

Sexually transmitted diseases (STDs) and bloodborne diseases are a reliable indicator of high-risk behavior (i.e., unprotected sexual intercourse) within populations and may increase the infectiousness of HIV.

AIDS has been a reportable disease in the U.S. and South Dakota since 1985. HIV infection without an AIDS diagnosis has been reportable in South Dakota since 1988, but is not yet reportable in all states. The tables and graphs provide information concerning South Dakota residents reported with HIV infection (non-AIDS) and AIDS.

The SD HIV/AIDS Surveillance Report is published semi-annually. Data contained in this report are provisional. Percentages may not equal 100% due to rounding. Questions regarding the surveillance report may be directed to the HIV/AIDS Surveillance Coordinator (1-800-592-1861 or 605-773-3737). This report is available on the SD Department of Health website at *www.state.sd.us/doh/disease/stats.htm* or write to HIV Surveillance, 615 East 4th Street, Pierre, SD 57501. For HIV/AIDS information 24 hours a day call 1-800-342-2437 or see *www.cdc.gov/nchstp/hiv_aids/dhap.htm*.

South Dakota Department of Health HIV/AIDS website:
www.state.sd.us/doh/Pubs/HIVhow.htm

Centers for Disease Control and Prevention HIV/AIDS website:
www.cdc.gov/hiv/dhap.htm

South Dakota Department of Health - Infectious Disease Surveillance

Selected Morbidity Report, 1 January – 31 March 2003 (provisional numbers)

Disease		2003 year-to-date	5-year median	Percent change
Vaccine-Preventable Diseases	Diphtheria	0	0	na
	Tetanus	0	0	na
	Pertussis	2	2	0%
	Poliomyelitis	0	0	na
	Measles	0	0	na
	Mumps	0	0	na
	Rubella	0	0	na
	Haemophilus influenza type b	1	0	na
Sexually Transmitted Infections and Blood-borne Diseases	HIV infection	6	6	0%
	Hepatitis B	1	0	na
	Chlamydia	595	439	+36%
	Gonorrhea	36	64	-44%
	Genital Herpes	90	80	+13%
	Syphilis, primary & secondary	0	0	na
Tuberculosis	Tuberculosis	9	3	+200%
Invasive Bacterial Diseases	Neisseria meningitidis	0	2	-100%
	Invasive Group A *Streptococcus*	13	5	+160%
Enteric Diseases	*E. coli* O157:H7	2	1	+100%
	Campylobacteriosis	18	18	0%
	Salmonellosis	18	17	+6%
	Shigellosis	8	14	-43%
	Giardiasis	12	21	-43%
	Cryptosporidiosis	6	3	+100%
	Hepatitis A	0	2	-100%
Vector-borne Diseases	Animal Rabies (through Feb 2003)	12	16	-25%
	Tularemia	0	0	na
	Rocky Mountain Spotted Fever	0	0	na
	Malaria	0	0	na
	Hantavirus Pulmonary Syndrome	1	0	na
	Lyme disease	0	0	na
	West Nile Virus disease	0	0	na
Other Diseases	*Streptococcus pneumoniae*, drug-resistant	0	0	na
	Legionellosis	0	1	-100%

Communicable diseases are obligatorily reportable by physicians, hospitals, laboratories, and institutions.
The **Reportable Diseases List** is found at www.state.sd.us/doh/Disease/report.htm or upon request.
Diseases are reportable by telephone, mail, fax, or courier.
Telephones: 24 hour answering device 1-800-592-1804; for a live person at any time call 1-800-592-1861; after hours emergency 605-280-4810. **Fax** 605-773-5509.
Mail in a sealed envelope addressed to the DOH, Office of Disease Prevention, 615 E. 4th Street, Pierre, SD 57501, marked "Confidential Medical Report".

2,500 copies of this Bulletin were printed by the Department of Health at a cost of $0.24 per copy.